STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE		ETED		
			B. WIN			10/17/	2013
			b. Will	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALLIANCE DR		
WODTHI	NGTON HOUSE				', IN 46113		
					, 114 40110		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
	This visit was fo	or a State Residential	R00	00000	Submission of this response a	nd	
	Licensure Surv		100	,0000	Plan of Correction is NOT a leg		
	Licerisure Surv	ey.			admission that a deficiency ex	-	
	Curroy datas:	October 15 16 and			or, that this Statement of		
	•	October 15,16, and			Deficiencies was correctly cited	d,	
	17, 2013				and is also NOT to be construct		
	Codiliby managers	. 002004			as an admission against intere by the residence, or any	st	
	Facility number				employees, agents, or other		
	Provider number				individuals who drafted or may	be	
	Aim number: N/A				discussed in the response or F		
					of Correction. In addition,		
	Survey team:				preparation and submission of		
	Patti, Allen, SW	V-TC			this Plan of Correction does No	OT	
	Marcy Smith, R	RN			constitute an admission or		
	,				agreement of any kind by the		
	Census bed typ	ne.			facility of the truth of any facts alleged or the correctness of a	nv.	
	Residential: 26				conclusions set forth in this	i i y	
		,			allegation by the survey agence	٠V.	
	Total: 26					,	
	Census payor t	type:					
	Other: 26	3 F -					
	Total: 26						
	Total. 20						
	Residential san	nnle: 7					
	residential san	npio. I					
	These State Da	esidential Findings are					
		ance with 410 IAC					
	16.2.						
	•	completed on October					
	22, 2013; by Ki	mberly Perigo, RN.					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIC	SNATURI	Ξ	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	B. WING 10/17/2015				
NAME OF P	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
WORTHI	NGTON HOUSE		10799 ALLIANCE DR CAMBY, IN 46113				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION			

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 2 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		10/17/2013	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
MODILII	NOTONIJIOLIOE			ALLIANCE DR		
WORTHI	NGTON HOUSE		CAMB	Y, IN 46113		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R000055	410 IAC 16.2-5-1 Residents' Rights					
	_	ve the right to be treated as				
		onsideration and respect				
		Privacy shall be afforded for				
	at least the follow	ring:				
	(1) Bathing.					
	(2) Personal care	ninations and treatments.				
	(4) Visitations.	matorio ana troatmente.				
	Based on obse	ervation, record review,	R000055	Citation # 1 R 055 410 IAC	11/30/2013	
	and interview,	the facility failed to		16.2-5-1.2(y)(1-4) Residents'		
	ensure a reside	ent's privacy was		Rights – Deficiency What		
	maintained dur	ing an insulin injection		corrective action(s) will be accomplished for those reside	ante	
	for 1 of 1 insuli	n injections observed.		found to have been affected by	I	
	This had the po	otential to affect 2		this deficient practice? LPN #	•	
	residents in the	e facility who received		received written disciplinary		
	insulin injection	ns. (Resident #1)		counseling and was reeducate	ed	
				to our policy regarding maintaining residents' privacy	,	
	Findings includ	le:		while administering insulin. H		
	_			the facility will identify other		
	The clinical rec	ord of Resident #1		residents having the potential		
	was reviewed of	on 10/15/13 at 12:40		be affected by the same defice practice and what corrective	ient	
	p.m.			action will be taken? The		
				Residence Director reviewed		
	Diagnoses for	Resident #1 included,		community practices regardin	g	
	but were not lin	nited to dementia and		maintaining resident privacy		
	insulin depende	ent diabetes mellitus.		during the administration of insulin injections, as well as o	ther	
				personal care or treatments.		
	During an obse	ervation of sliding scale		Licensed nursing staff were		
	insulin adminis	tration on 10/16/13 at		re-educated on maintaining		
	11:50 a.m., Lic	ensed Practical Nurse		resident privacy during the administration of insulin		
	(LPN) #1 remo	ved Resident #1, in her		injections. New licensed staff	will	
	wheelchair, fro	m the dining room.		also be educated to the above		
	She took the R	esident to the corner of		upon hire. What measures wi	I	
	2 hallways, app	proximately 20 feet		put into place or what system	I	
	from the west e	entrance to the dining		changes will the facility make	to	

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		10/17/2013		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			ALLIANCE DR			
W∩DT⊔ı	NGTON HOUSE			ALLIANCE DR /, IN 46113			
WORTH	INGTON HOUSE		CAIVIB	, IIN 1 0113			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	room. She told	Resident #1 she was		ensure that the deficient pract	ice		
	aoina to aive h	er insulin, pulled the		does not recur? The staff wer			
		he Resident's pants		re-educated to the Indiana Sta	nte		
		nately 2 inches, and		regulation R 055 410 IAC			
		-		16.2-5-1.2(y) (1-4) Resident			
	-	up approximately 2		Rights and our policy and	na		
	•	ng the residents bare		procedure regarding maintaini resident privacy. The Resider			
		then injected the		Director and/or Designee will I			
	Resident's insu	ılin into her exposed		responsible for ensuring resident			
	stomach, while	in the hallway.		privacy is maintained during the			
		-		administration of insulin			
	During an inter	view with the Wellness		injections. How will the correct	tive		
	_	16/13 at 3:00 p.m., she		action(s) will be monitored to			
		•		ensure the deficient practice w	<i>i</i> ill		
		ents receiving insulin		not recur, i.e., what quality			
	_	ld be taken to their		assurance program will be put			
	room or into a i	restroom for privacy.		into place? The Residence			
				Director and/or Designee will I	oe		
	During an inter	view with the		responsible for monitoring			
	_	ector on 10/17/13 at		resident privacy while injecting insulin through weekly rounds			
		e indicated LPN #1 had		the community to ensure	5 01		
	-	ed inservice training		continued compliance with the			
		•		above referenced regulation for			
	_	garding maintaining		period of (6) six months. Rou			
	•	cy while injecting		will be completed randomly,			
	insulin.			across all shifts and including			
				weekends. Findings will be			
				reviewed and corrected through	jh		
				the Worthington house QA			
				process. A Quality Assurance			
				meeting will be held after (6) s	I		
				months to determine the need	TOF		
				the ongoing monitoring plan. Findings suggestive of			
				compliance result in cessation	of		
				the monitoring plan. Cessation	I		
				the monitoring plan will be bas			
				upon results of random review			
				that indicate no additional area	I		
				of concern concerning the abo			
				1			

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 4 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SUF COMPLETE 10/17/20	ED
	ROVIDER OR SUPPLIE	R	10799	ADDRESS, CITY, STATE, ZIP CODE ALLIANCE DR Y, IN 46113		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		(X5) OMPLETION DATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	referenced regulatory criter. The Regional Director of Q and Care Management and Designee will complete Qu site visits of community to continued compliance. By date will the systemic chan completed? 11/30/2013	ria. uality d/or arterly ensure what	DATE

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 5 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA							X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
			B. WIN		10/17/2		2013	
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	L.			ALLIANCE DR			
WORTHI	NGTON HOUSE				Y, IN 46113			
		TA TENTE OF DEPLOYED OF	-		,	1	(7/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
R000144			+	IAU			DATE	
K000144	410 IAC 16.2-5-1	afety Standards - Deficiency						
		all be clean, orderly, and in						
	` '	epair, both inside and out,						
		reasonable comfort for all						
	residents.							
	Based on obse	rvation and interview,	R00	00144	Citation #2 R 144 410 IAC		11/30/2013	
	the facility faile	d to maintain clean			16.2-5-1.5 (a) Sanitation and			
	resident apartn				Safety Standards -			
	resident apartn				Deficiency What corrective			
	•				action(s) will be accomplished	tor		
	uncleanliness of apartments affected Resident #3 and #20.				those residents found to have been affected by this deficient			
	Nesident #5 an	iu #20.			practice? Resident #3's carpe			
	Findings Include:				was professionally cleaned.			
					Resident #20 has a history of			
					"hoarding behavior". The			
		tour was done on			Residence Director met with the	_		
	10/17/13 at 10:	45 a.m., with the			family of Resident #20 to discu	JSS		
	facility Mainten	ance Service Director			the uncleanliness of the			
	and Resident D	Director with the			apartment. Resident #20 will move to a new apartment with	in		
	following obser	vations:			the residence. The Residence			
					Director and the National Director			
	1. In Resident	#3's apartment, the			of Resident Life Enrichment a	re		
		out the apartment was			currently revising an appropria			
		multitude of stains, in			plan of care regarding Reside	nt#		
		sizes; starting at the			20's history of such behavior.			
		_			How the facility will identify o			
	· •	rance door. One			residents having the potential be affected by the same defici			
	resident occup	ied this apartment.			practice and what corrective	CIIL		
		"00!			action will be taken? The			
		#20's apartment, there			Residence Director conducted	l		
		oath that lead to the			rounds of the Residence to			
	Resident's bed	. The carpet that was			ensure compliance with R 144			
	visible was soil	ed and had stains			410IAC 16.2-5-1.5(a). No			
	blackish/gray ir	n color. The floor was			residents were found to be	ho		
		apers, books, clothes,			affected. What measures will put into place or what systemi			
	•	es approximately 3 feet			changes will the facility make			
		e room. The rest room			ensure that the deficient pract			
						-		

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 6 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	ON (X3) DATE SU COMPLE SU 10/17/2			
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 10799 ALLIANCE DR CAMBY, IN 46113				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Appers, books, boxes,	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY) does not recur? The Res	ROPRIATE sidence	(X5) COMPLETION DATE	
	totes, and other the closet had and on it, almost furniture, windowere covered witems. There with the Reside apartment. Shows full and coclothes. House cleans around occupied this a linear an interview Director after environment of the control of	er items. The shelf in stuff stacked up to it set to the ceiling. The low sill, and counter with the same type of was an accumulation of an these items apartment. Interview ent at time of tour of the line indicated her dresser ould not hold any other ekeeper comes in and her stuff. One resident apartment. I with the Resident environmental tour on indicated she was oncerns found in a partment and has with the family and expast several months. I with the housekeeper ental tour on 10-17-13,		Director was re-educated National Director of Residentichment on lifelong to the staff has been re-educated to report uncleanliness or resident apartment and/or stains. A carpet cleaning schedule will be put into. The Residence Director Designee are responsible ensure resident apartment a state of good repair to compliance with Indiana regulation R144 410 IAC 16.2-5-1.5(a). How will be corrective action(s) will be monitored to ensure the practice will not recur, i.e. quality assurance program put into place? The Resident perform random weekly a carpet sanitation in resident apartments using the QA Housekeeping to ensure continued compliance for of (6) six months. The Resident #20's apartment the QA audit for Housekeeping to ensure continued compliance for of (6) six months. The Resident #20's apartment the QA audit for Housekeeping to ensure continued compliance for the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure continued compliance for the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure continued compliance for the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure continued compliance for follows. The Resident #20's apartment the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure continued compliance for follows. The Resident #20's apartment the QA audit for Housekeeping to ensure the QA audit for Housekeeping to ensure continued compliance for follows. The Resident #20's apartment the QA audit for Housekeeping to ensure the QA a	I by the dent Life barding. Iducated frany or carpet grand/ or ento ents are in ensure State the endeficient endits of ent's entits entits of ent's entits ent		

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 7 of 13

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COME	e survey Pleted 7/2013
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C		112013
WORTHI	NGTON HOUSE			Y, IN 46113		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR: (EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE ADEFICIENCY)	RECTION HOULD BE PPROPRIATE	(X5) COMPLETION DATE
IAU	REGULATORY OF	A LOC IDENTIFYTHING INFORMATION)	IAG	compliance result in cethe monitoring plan. Cethe monitoring plan will upon results of random that indicate no addition of concern concerning referenced regulatory of The Regional Director Operations and/or Descomplete Quarterly site community to ensure of compliance. By what the systemic changes is completed? 11/30/201	essation of lessation of l be based n reviews nal areas the above criteria. of ignee will e visits of continued date will be	DATE

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 8 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
			B. WING			10/17/	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				ALLIANCE DR		
WORTHII	NGTON HOUSE		CAMBY, IN 46113				
					, , , , , , , , , , , , , , , , , , , ,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000349	410 IAC 16.2-5-8	. , . ,					
	Clinical Records -						
	` '	ust maintain clinical records					
		These records must be					
		the supervision of an facility designated with that					
		e records must be as					
	follows:	c records must be as					
	(1) Complete.						
	(2) Accurately do	cumented.					
	(3) Readily acces						
(4) Systematically organized. Based on record review and interview, the facility failed to ensure		/ organized.					
		R00	0349	Citation #3 R 349 410 IAC		11/30/2013	
				16.2-5-8. 1(a)(1-4) Clinical			
		s were complete and			Records – Noncompliance Wh	nat	
		umented regarding			corrective action(s) will be		
		cation for 1 of 7			accomplished for those reside		
		ed for completeness			found to have been affected b this deficient practice? When	у	
		•			Resident #1's blood sugar is		
	•	of documentation in a			outside of physician ordered c	all	
	sample of 7. (F	Resident #1)			parameters, licensed nursing		
					will document the physician		
	Findings includ	e:			notification in the resident's		
					clinical record. How the facility		
	The clinical rec	ord of Resident #1			identify other residents having	the	
	was reviewed 1	10/15/13 at 12:40 p.m.			potential to be affected by the	h-4	
					same deficient practice and will corrective action will be taken'		
	Diagnoses for I	Resident #1 included,			Wellness Director conducted a		
	but were not lin	·			review of the clinical records of		
		petes mellitus and			residents receiving insulin to		
	dementia.	ocics memitas and			ensure records were complete)	
	ucilicilla.				and accurately documented		
	A				pertaining to physician notifica		
	-	physician's order for			of blood sugars outside of call		
		with an original date			parameters. No other residen		
	of 6/20/11, indi	cated Resident #1 was			were found to be affected. When measures will be put into place		
	to receive accu	ichecks 3 times per			measures will be put into place what systemic changes will the		
	day at 7:00 a.m	n., 11:30 a.m., and			facility make to ensure that the		
	•	accucheck is a finger			deficient practice does not rec		

State Form Event ID: 7Q2011 Facility ID: 003984 If continuation sheet Page 9 of 13

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		B. WING		10/17/2013
	l .	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER		ALLIANCE DR	
WORTH	INGTON HOUSE		γ, IN 46113	
_			.,	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROP	RIATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	· ·	DATE
	stick blood test done to measure		Licensed Nursing Staff were in-serviced on documentation	
	blood sugars.		regarding physician notificat	
			Education regarding proper	
	A recapitulated physician's order for		documentation of physician	
	October, 2013, with an original date		notification will be provided	to
	of 7/1/12, indicated the physician was		new licensed nursing staff u	
	to be notified if Resident #1's		hire to Worthington House.	
	accucheck results were less than 80		Residence Director and/or	
			Designee will be responsible	
	or over 400.		ensuring clinical records are	
			complete and accurately	
	Medication Administration Records		documented regarding phys	
	(MAR) for September, 2013, indicated		notification to ensure compl with Indiana State regulation	
	the following regarding Resident #1's		R349 410 IAC 16.2-5-8.1(a)	
	accucheck results:		Clinical Records. How will t	
			corrective action(s) will be	
	9/2/13 11:30 a.m. blood sugar = 70		monitored to ensure the defi	icient
	9/9/13 4:00 p.m. blood sugar = 71		practice will not recur, i.e., w	/hat
			quality assurance program v	
	9/15/13 4:00 p.m. blood sugar = 74		put into place? The Wellnes	
	9/16/13 4:00 p.m. blood sugar = 74		Director and/or Designee wi	
	9/17/13 4:00 p.m. blood sugar = 55		perform weekly audits of the	
	9/25/13 4:00 p.m. blood sugar = 70		Medication Administration R	
	9/26/13 4:00 p.m. blood sugar = 60		for accucheck results outsid call parameters and appropri	
	9/29/13 4:00 p.m. blood sugar = 71.		documentation of physician	iale
			notification regarding these	
	MAR's for August, 2013, indicated the		results to ensure continued	
	<u> </u>		compliance for a period of (6	
	following regarding Resident #1's		months. Findings will be	,
	accuchecks:		reviewed through the Worth	
			House QA process after (6)	
	8/1/13 4:00 p.m. blood sugar = 73		months to determine the nee	
	8/14/13 4:00 p.m. blood sugar = 64		an ongoing monitoring plan.	
	8/15/13 4:00 p.m. blood sugar = 77		Findings suggestive of	
	8/21/13 4:00 p.m. blood sugar = 60		compliance will result in ces	
	8/23/13 4:00 p.m. blood sugar = 75		of the monitoring plan. Cest of the monitoring plan will be	
	8/24/13 4:00 p.m. blood sugar = 57		based upon the results of ra	
			reviews that indicate no add	
	8/26/13 4:00 p.m. blood sugar = 61		Toviews that indicate no add	iuonai

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COME	O DATE SURVEY COMPLETED 10/17/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 10799 ALLIANCE DR CAMBY, IN 46113					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	No documenta Resident #1's r physician had regarding the a below 80. During an inter Director on 10/ further informa regarding whet physician had Resident #1's \$ 2013, blood su parameters. T indicated at the exception." Sh	view with the Wellness 16/13 at 10:00 a.m., tion was requested ther or not the been notified of September and August, gars outside of call he Wellness Director at time, "We chart by the indicated the nurses ied the physician and		areas of concern con above referenced reg criteria. The Regiona Quality and Care Mar and/or Designee will a quarterly random on of the Medication Adr Records / Clinical recensure continued con By what date will the changes be complete 11/30/2013	gulatory al Director of magement also perform site reviews ministration cords to mpliance. e systemic			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
			B. WIN			10/17/	2013
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALLIANCE DR		
WORTHII	NGTON HOUSE						
	NOTONTIOUSE		CAMBY, IN 46113		, 114 40110		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000414	410 IAC 16.2-5-1	• •					
	Infection Control	-					
		ust require staff to wash each direct resident contact					
		ashing is indicated by					
	accepted profess	-					
		rvation, interview, and	R00	0414	Citation #4 R 414 410 IAC		11/30/2013
		the facility failed to		V 11 1	16.2-5-12(k) Infection Control	-	11/50/2015
		ashed their hands			Deficiency What corrective		
		donning and removing			action(s) will be accomplished	for	
		ninistering eye drops			those residents found to have		
	_				been affected by this deficient		
	and insulin. This had the potential to				practice? Licensed Practical Nurse (LPN) #1 was re-educate	od	
	affect 26 of 26 residents residing in				on our policy and procedure	.eu	
	the facility.				Preventing Transmission of		
					Infection. How the facility wil	l	
	Findings includ	e:			identify other residents having	the	
					potential to be affected by the		
	During an obse	ervation of medication			same deficient practice and wh		
	pass on 10/16/	13 at 11:30 a.m.,			corrective action will be taken? The Wellness Director observe		
	Licensed Pract	ical Nurse (LPN) #1			the licensed nursing staff durir		
		er to her hands, gave a			medication pass using the	ig a	
	• •	Resident #3, applied			"Medication Pass Competency	,	
	sanitizer to her	· • •			Checklist" and found them to b	e	
		Resident #9, then			in compliance. No other		
		, administered eye			residents were affected. Wh		
	•	•			measures will be put into place		
	=	ent #9, removed her			what systemic changes will the		
	•	sanitizer, gave			facility make to ensure that the deficient practice does not rec		
		Resident #20, applied			The licensed nursing staff were		
	sanitizer, gave				re-educated to the Indiana Sta		
	•	pplied sanitizer,			ruling R 414 IAC 16.2-5-12(k)		
	applied gloves,	gave insulin to			Infection Control and our polic	y	
	Resident #1, re	emoved gloves and			and procedure on Preventing		
		er. At no time during			Transmission of Infection.		
	• •	of events was LPN #1			Education on the above will be		
	observed to wa				provided to new licensed nursi staff upon hire to Worthington	iig	
	5555. 754 to WC	.cc. riarido.			House. The Residence Direct	or	
						~ 1	

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	TO OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/17/2013	
	PROVIDER OR SUPPLIER NGTON HOUSE	10799 AL	STREET ADDRESS, CITY, STATE, ZIP CODE 10799 ALLIANCE DR CAMBY, IN 46113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	A facility policy, titled, "Preventing Transmission of Infection," dated 1/1/13, received from the Residence Director on 10/15/13 at 3:00 p.m., indicated, "II. Staff should always thoroughly wash their hands in the following situations:After any possible contact with blood or other body fluids, even if wearing gloves;after removing gloves;" During an interview with the Wellness Director on 10/16/13 at 3:00 p.m., she indicated, "Nurses should wash their hands after removing gloves."		and/or Designee will be responsible to ensure complia with the above referenced regulation. How will the corrective action(s) will be monitored to ensure the deficience of the practice will not recur, i.e., who quality assurance program who put into place? The Residence Director and/or Designee will conduct weekly audits of medication pass looking for proper hand washing techniq to ensure continued compliant for a period of (6) six months. These rounds will be complete randomly, across all shifts, including weekends. Finding be reviewed through the Worthington House QA proceafter (6) six months to determ the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan will be based upon results of random review that indicate no additional are of concern concerning the abreferenced regulatory criteria. The Regional Director of Qualind Care Management and/or Designee will complete Quart site visits of community to encontinued compliance. By we date will the systemic change completed? 11/30/2013	ient nat ill be ce ues nce eted s will ess nine f the ws eas ove lity or eerly sure hat	

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